Child Welfare Caseload Management

Second Follow-up Report
December 2007

Office of Performance Evaluations
Idaho Legislature

Report 07-09F

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Acknowledgments

We appreciate the cooperation and assistance we received from the Department of Health and Welfare. Carrie Parrish and Maureen Shea of the Office of Performance Evaluations conducted this follow-up review, and Amy Lorenzo performed the quality review. We also contracted with Bob Thomas of Robert Thomas Consulting to assist with the follow-up review.

Child Welfare Caseload Management

Second Follow-up Report

In February 2005, we issued a report on caseload management in the Department of Health and Welfare's Child Welfare program. In this follow-up review, we found the department has made significant progress in addressing our recommendations for improving Child Welfare caseload and workload management.

Background

The Idaho Department of Health and Welfare's Child Welfare program provides child protection, foster care, and adoption services. In 2004, the Joint Legislative Oversight Committee directed us to conduct a study of the Child Welfare program because of growing caseloads and deficiencies identified in the 2003 federal Child and Family Services Review.[1] To strengthen management and accountability in Child Welfare, we made seven recommendations to the department in our February 2005 report.

Caseload
The number of cases that workers are assigned in a given time period. Caseloads may be measured for individual workers, all workers assigned a specific type of case, or all workers in a particular office or region.

Workload
The amount of work required to address assigned cases. Measuring workload requires an assessment of (1) the factors that impact the time it takes to work cases and (2) the time workers spend on activities not directly related to their case responsibilities.

Current Status

Following our 2005 report, the department has taken steps to address our recommendations for strengthening management and accountability in Child Welfare. In April 2006, the department received praise from the federal government for successfully completing its Program Improvement Plan, which involved implementing major system-wide initiatives and meeting program goals. In appendix A, the department has

[1] The 2003 federal Child and Family Services Review found deficiencies related to safety, permanency, and well-being standards in the department's Child Welfare program. The department developed the 2004 Program Improvement Plan to specifically address those deficiencies and avoid federal penalties.

provided an update on its most recent progress regarding Child Welfare caseload management. Our assessment of the department's implementation efforts is in the following sections.

Caseload Information

Recommendation numbers refer to numbers in our 2005 report.

Recommendation 3.1: *To improve caseload management in the Child Welfare program, the Department of Health and Welfare should take steps to ensure caseload information is accurate. This may include*

- *modifying the Family Oriented Community User System (FOCUS) to address problems, such as adding an inactive status field to allow the system to count only* active *cases; and*
- *establishing a method to collect caseload information outside FOCUS.*

In 2005, we reported that the Department of Health and Welfare had a limited ability to collect accurate information about staff caseloads. Data entry into Child Welfare's FOCUS was complicated and not consistently up to date. FOCUS could not distinguish between actively worked cases and those no longer receiving attention but not officially closed, causing an inaccurate calculation of caseloads.

The department is currently implementing an automated function within FOCUS that will produce reports of all active and inactive cases. In September, the department presented to its supervisory staff a prototype of these reports and plans to make them available statewide in December 2007.

Our 2005 evaluation found that inefficiencies in data entry made it difficult to determine the number of active cases. We recommended that the department collect caseload information outside of FOCUS to more accurately and easily determine the work responsibilities of staff. The department continues to refine its collection of data outside FOCUS by conducting quarterly caseload surveys with input from program managers, supervisors, and staff. Most recently, the department revised the quarterly caseload survey instructions to better clarify particular categories and definitions for supervisors completing the surveys. This second, independent data collection method can provide additional accuracy and reliability. However, the department has no process in place to verify that the supervisors are gathering data independent of the data entered into FOCUS. Currently, caseload survey accuracy and reliability is limited given the potential for supervisors to use FOCUS data when completing the caseload survey.

Status: This recommendation has been **implemented**. We encourage the department to develop guidelines outlining how supervisors should collect their quarterly caseload survey data independent of FOCUS.

Child Welfare Management

Recommendation 5.1: *To obtain workload information for Child Welfare program staff, the Department of Health and Welfare should*

- *employ an on-going, cost-effective method of measuring the amount of time staff spend on different types of cases and activities in relation to program outcomes;*
- *analyze key factors that impact the time it takes staff to work cases and perform specific tasks; and*
- *work with a steering committee that includes department representatives and other key stakeholders—such as representatives of the court system, the Office of the Governor, and the Legislature—to develop the methods used for regular collection of workload information.*

In our 2005 report, we said that the workload in the Child Welfare program was growing, yet the Department of Health and Welfare did not have a systematic way to measure workload or estimate staffing needs. In response to our recommendation, the department selected the American Humane Association to conduct a study of workload in the Child Welfare and Children's Mental Health programs.[2] A committee of department representatives was involved in the workload study process. In April 2007, the American Humane Association published the results of its study and has provided the department with an analytical tool that can be used for future in-house workload measurement studies.

Workload Study Limitations

The department is cautious in judging the validity of analysis used in the association's study. This caution stems from three areas of concern: (1) inconsistency in how workload was recorded among regions, (2) the relationship of certain case characteristics to workload, and (3) the connection between workload and program outcomes. We agree that the department should exercise caution in how it uses the information from the study. Potential problems encountered in the American Humane Association's study can be addressed when the department conducts its own in-house workload assessments in the future.

[2] The American Humane Association workload study took place in 2006, before the Children's Mental Health program became a part of the newly formed Division of Behavioral Health [Executive Order 2006-18].

Understanding the Need for Additional Staff

Although the department has noted certain limitations of the association's study, it believes the aggregate workload data strongly supports the need to increase the number of social workers and clinicians. The workload data portrays how much time existing staff spend doing their work, not how much time they should have spent. Based on our review of the association's study, we conclude the workload data provides valuable information, but the data by itself does not necessarily suggest the need for additional social workers or clinician staff. The study concludes that more staff are needed based on comparing the measured workload of staff to service standards set by the department; however, these service standards are based on the judgment of department headquarters staff, and as such, are subjective in nature.[3]

The department considers the service standards developed for use in the American Humane Association's study to be guidelines or targets to reach federally defined client outcome standards. The department's primary goal is to provide positive client outcomes, not to meet prescribed staffing targets. According to department officials, the current caseload management in combination with other service initiatives (such as streamlining work processes and improving staff training) may enhance client outcomes without meeting all of the service standards.

Future In-house Workload Assessments

The department plans to use the tool and framework established by the association's study to conduct future in-house workload assessments. The department anticipates conducting its first in-house assessment in mid to late 2009. As a part of these future in-house assessments, the department is planning to engage in process mapping of how its offices handle casework and related activities.[4] Process mapping will further identify and set benchmarks for the most cost-effective workload processes. In light of the association's study limitations, OPE and the department have identified other actions that could help improve future in-house studies:

- Resolve issues related to how service categories are defined (such as intake, assessment, in-home placement, and out-of-home placement),

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[3] Service standards outline the time department staff need to provide required services on a case. The American Humane Association's study said the standards used were based on the minimum workload needed to meet all legal, policy, and ethical requirements in a timely manner. However, the department could not demonstrate how the service standards were linked to any specific requirements. Department headquarters staff confirmed that the standards were based on what the department referred to as "professional judgment."

[4] Process mapping is an analysis of staff work and the process for accomplishing each task. Process mapping can assist with improving the cost-effectiveness of operations.

thus ensuring that each region is consistently using the same definitions in future workload surveys

- Attain consensus on which case characteristics should be used for measuring the effect on workload[5]
- Consider making the coding of case characteristics mandatory, or use sampling or another methodology to ensure confidence in the results of the case characteristics analysis
- Analyze supervisory and support staffing needs in relation to work required rather than relying on historical staffing ratios[6]
- Generate service standards through a more verifiable and reliable process

With the help of the American Humane Association, the department has established a foundation for analyzing the key factors impacting workload. The association study provided the department with the number of staff needed to meet workload standards set by the department. However, due to study limitations and the process by which the workload standards were set, the association's suggested staffing levels should not be considered precise. By implementing the actions listed above, future studies would be able to better describe the influence of case characteristics on workload as well as the relationship between staff workload and outcomes. With such information, the department will significantly increase its ability to define what it will accomplish by investing in more staff.

Status: This recommendation is **in process.**

Recommendation 5.2: *To ensure program staff are fairly distributed among regions, the Department of Health and Welfare should use caseload and workload information when making staff allocation decisions, and when measuring, analyzing, and monitoring performance.*

Our 2005 study reported that the Department of Health and Welfare rarely reallocated positions among regions and relied on general information to make staffing decisions. The American Humane Association looked at this issue in its study and concluded that there was a substantial need to adjust workload by increasing staff resources.

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[5] Case characteristics are defined by the department and are factors (such as substance abuse or mental health issues) that impact the amount of effort or time involved in the workload for certain children or families.

[6] The association's study recommended increases in supervisory and support staff in proportion to the recommended increases in social workers and clinicians. This recommendation for more supervisory and support staff was based on maintaining historical ratios; it was not based on a separate analysis of supervisory and support staffing needs.

In its response to the study, the department indicates that in addition to its service initiatives, it will make incremental reallocations of staff in three ways: (1) shifting some existing staff, (2) moving vacancies between regions, and (3) making further adjustments if new full-time employees are approved. The department reallocates staff based on a weighted formula, and the department has modified the formula to incorporate staffing recommendations made by the association's study.

The department's approach to staff reallocations is based on the idea that major staff reallocation can have a negative impact on morale and performance if regions are understaffed to begin with. Therefore, the department is focused on incremental reallocations of existing staff rather than major reallocations. Use of periodic future in-house workload assessments will help to provide stronger guidance for balancing caseload and workload.

Status: This recommendation has been **implemented**.

Recommendation 5.3: *To increase program accountability, the Department of Health and Welfare should annually report accurate caseload and workload information to the Office of the Governor and the Legislature. This information should include*

- *average caseloads by case worker type (e.g., risk assessment, case management);*
- *caseload distribution among case workers in each region, such as high and low caseloads;*
- *caseload differences among regions;*
- *major workload components for each region, including the number of children in foster care, and the number of legal and voluntary cases;*
- *annual statewide summaries of the total number of risk assessment, case management, adoption, and independent living cases;*
- *comparison of caseloads to department caseload standards; and*
- *comparison of program performance measures to key outcomes identified in the department's Program Improvement Plan, which was developed to address issues raised in the federal Child and Family Services Review.*

In 2005, we reported that the Department of Health and Welfare provided only limited information to policymakers regarding caseload and workload within the Child Welfare program. The department collects the type of data we recommended through FOCUS, quarterly caseload surveys, and the recent American Humane Association study. At the time of our first follow-up review

in 2006, the department said it planned to begin reporting the recommended information to policymakers in the 2007 legislative session. To date, the department has not provided the recommended information to the Office of the Governor and the Legislature. However, the department now states it will work with the Office of the Governor and the Legislature to select a useful format and frequency of reporting this data.

Status: Because the department has not yet provided the recommended information to the Office of the Governor and the Legislature, this recommendation has **not been implemented**.

Recommendation 5.4: *To assess the impact of the "Any Door" initiative on the Child Welfare program, the Department of Health and Welfare should conduct a formal, in-house analysis identifying the number of staff transferred to "Any Door" and the initiative's effect on staff workload. The results of this analysis should be reported to the Office of the Governor and the Legislature.*

The Any Door initiative, now called Navigation, is a Department of Health and Welfare effort to improve the integration of services. The department created multi-disciplinary navigation teams that are responsible for assessing client needs and eligibility for various department services. The teams are also responsible for directing clients to the appropriate programs within the department. Six department programs have contributed a total of 27 staff to the Navigation initiative, of which, 4.7 full-time positions have been from Child Welfare.

To date, the department has not directly assessed the impact of the Navigation initiative on staff workload in Child Welfare. The department indicates it has not done so because an analysis of the Navigation initiative cannot be reliably conducted. According to department officials, they are unable to directly correlate the Navigation initiative with staff workload due to program changes since 2004. For example, extending staff training, modifying the case review system, and strengthening quality assurance may have an effect on program workload, making it difficult to directly link Navigation alone to changes in program workload.

Status: Given the continuing improvement in Child Welfare program outcomes and the variety of programmatic changes that have taken place in recent years, the department has no plans to conduct a formal, in-house analysis of the effect of the Navigation initiative. We find department efforts to monitor program outcomes and staff workloads meet the intent of this recommendation. This recommendation has been **addressed.**

Child Welfare Financing

Recommendation 6.1: *To better access federal Title IV-E funding, the Department of Health and Welfare should continue to work with the Court Improvement Project to improve the state's Title IV-E eligibility rate. This could include expanding training for judges and prosecutors to ensure*

- *court orders include language required in federal and state statutes; and*
- *12-month permanency hearings are held in a timely and consistent manner.*

Title IV-E of the Social Security Act provides federal funding to assist states with the costs of serving children in foster care, children aging out of the foster care system, and special needs children who have been adopted because of child protection concerns. The Resource Development Unit within the Division of Family and Community Services determines whether a child is eligible for funds and ensures compliance with the federal rules of Title IV-E. In 2005, we reported that Idaho was losing Title IV-E funding for foster care children due to inadequate language in court orders and untimely permanency hearings.[7]

The department works with the Court Improvement Project to improve the eligibility rate for Title IV-E.[8] The Resource Development Unit and the Court Improvement Project have made efforts to raise awareness regarding Title IV-E and to provide technical guidance and training for judges. In May 2006, the courts conducted a multidisciplinary training on Title IV-E as part of an annual magistrate institute for all Idaho judges. The institute touched on the topic again in 2007 when updating judges about a change in statute. Additional training on Title IV-E will occur at the institute in 2008 as part of an overall training on how to complete a child protection case.

In June 2007, the Department of Health and Welfare received the results of its federal review of the Title IV-E eligibility process. The review found Idaho substantially compliant.[9] The reviewers praised Idaho for making significant progress in the quality of court orders since the last review in 2004, and they stated that the Resource Development Unit consistently completed re-determinations of eligibility in a timely manner.

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[7] Initial determinations of eligibility for Title IV-E are made when children first enter foster care and re-determinations of eligibility are made every six months while children remain in foster care. Children can lose eligibility for Title IV-E when they initially come into foster care, at the time of re-determinations (6 months), or if permanency hearings (12 months) are not held on time.

[8] The Court Improvement Project began in 1998, following the passage of the Adoption and Safe Families Act in the previous year. The project consists of a multidisciplinary approach to dealing with child protection issues and working with the court.

[9] The federal review drew a *sample* of 80 cases from all Title IV-E cases. Idaho was found to be in substantial compliance with federal criteria, because no more than 4 of the *sample* cases were in error.

Although the department passed its most recent federal review, department officials were unable to provide us sufficient data to illustrate whether they made improvements regarding the Title IV-E eligibility process since our 2005 report. During fiscal year 2007, only 58 percent of Title IV-E applicants qualified for federal funds. An unofficial count of applicants for January through June 2007 showed that 32 percent did not qualify because of family income restrictions. Of the remaining 10 percent, the department reports that some did not qualify for federal funds because federally-required language was missing in the court order or a hearing was not timely. At the time of this report, department officials had not completed a breakdown of ***all*** specific reasons why the remaining 10 percent of applicants did not receive federal funding. Improved data management would help the Resource Development Unit track reasons for ineligibility and develop strategies that might improve the eligibility rate and gain access to additional federal funds.

Status: This recommendation is **in process**.

Recommendation 6.2: *To assess the workload and resource needs of the Resource Development Unit, the Department of Health and Welfare should*

- *determine the appropriate level of technical and other support needed by the unit to ensure timely and accurate eligibility determinations;*
- *assess current workload levels as a result of the increases in the number of children entering foster care; and*
- *conduct a formal analysis to estimate cost savings that could be achieved by adding positions in the Resource Development Unit to increase federal Title IV-E funding.*

Our 2005 report identified the need to potentially increase the size and level of technical and clerical support of the Resource Development Unit. A 2004 federal audit found that, based on size and client population, the Resource Development Unit had fewer staff working on eligibility determinations than comparable states. As part of its workload study, the American Humane Association included a separate analysis of the Resource Development Unit workload and staffing needs.

We found the American Humane Association's analysis did not discuss the adequacy of work performed or the adequacy of time spent to do the work. The analysis also contained an apparent inconsistency or error in the number of staff reporting time on Resource Development Unit activities. The American Humane Association did not provide adequate information to determine the appropriate number of staff needed to perform the work of the Resource Development Unit.

The third part of our recommendation calls for an estimated cost-savings analysis to illustrate the benefit of adding staff to the Resource Development Unit. The department was unable to provide a current analysis for cost savings that would justify its request for more staff. We suggest the department follow the approach it used for the Estate Recovery program to estimate how additional staff would increase revenues within the Division of Medicaid.

Status: This recommendation has **not been implemented**.

Appendix A

Update of Implementation Efforts

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 13, 2007

Mr. Rakesh Mohan, Director
Office of Performance Evaluations
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Lower Level, Suite 10
P.O. Box 83720
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Dear Mr. Mohan:

The Department of Health and Welfare is pleased to present the attached documents relating to its completion of the Child Welfare Workload Study. These documents represent the Department's implementation of recommendations emanating from the Child Welfare Caseload Management report issued in February 2005 by the Office of Performance Evaluation.

The first is the final report by the Department's contracted vendor, the American Humane Association, entitled "Idaho's Workload Analysis Survey and Staff Allocation Model." This report outlines the methodology of the study, data on factors affecting workload, and construction of a staff allocation model.

The second is the report by the Department on its review and analysis of the workload study, "Department of Health and Welfare Perspectives on the American Humane Association's Report." After summarizing the most salient features of the data collection and analysis of the American Humane Association, this report highlights how the Department will use the workload data and pursue additional strategies in allocating and supporting staff. It also specifies how the Department has fully addressed each of seven recommendations of the Office of Performance Evaluation.

We encourage you to review the attached and forward it to the Joint Legislative Oversight Committee at your earliest convenience. Questions on this response should be directed to Ms. Michelle Britton, Administrator, Division of Family and Community Services.

Sincerely,

RICHARD M. ARMSTRONG
Director

RMA/fs

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Department of Health and Welfare Perspectives on the American Humane Association's Report:

"Idaho Workload Analysis Survey

and

Staff Allocation Model"

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Department of Health and Welfare Perspectives on the American Humane Association's Report: "Idaho Workload Analysis Survey and Staff Allocation Model"

I. Introduction

The Department of Health and Welfare is pleased to offer its comments on and to propose actions regarding the results of the recently completed child welfare Workload Analysis Survey and Staff Allocation Model (WASSAM). Through a Request for Proposal (RFP) process, the Department procured the services of the American Humane Association (AHA) to conduct a time survey of workload activities and collaborate with the Department in analyzing key factors affecting workload. This WASSAM project has fulfilled the recommendations presented by the Office of Performance Evaluation (OPE) in its February 2005 Report, Child Welfare Caseload Management.

This project specifically meets Recommendation #2 of the OPE report, which indicated, "the Department should: a) employ an on-going method of measuring the amount of time staff spend on different types of cases and activities, b) analyze the key factors that impact the time it takes staff to work cases, and c) work with a steering committee ... to develop methods for regular collection of workload information."

In fulfilling this recommendation through this survey, the Department has demonstrated the capacity to:

- Measure Children and Family Services (CFS) and Children's Mental Health (CMH) workload accurately
- Identify CFS and CMH workload standards needed to achieve client outcomes, as mandated by federal standards and best practice
- Compare actual workload against standards to determine staffing needs based on empirical data
- Reallocate existing staff more effectively and equitably
- Determine CFS and CMH staffing needs
- Gain insight into the relative impact of case characteristics on workload

II. Workload Management in the Context of Pursuing Child Welfare Outcomes

Before discussing the Workload Survey proper, the Department must depict the context within which its workload management efforts operate. Workload management is one of several inter-related, tactical approaches toward the implementation of a comprehensive strategy to meet the following child welfare outcomes:

1. Safety: Children are protected from abuse and neglect
2. Permanency: Children have permanent and stable living arrangements and family relationships
3. Well-Being: Children receive appropriate services to meet their educational, physical, and mental health needs

DHW PERSPECTIVES ON AHA REPORT

Calling on evidence-based best practices throughout the nation, the federal Administration for Children and Families (ACF) has established these three outcomes, as measured by 23 specific performance indicators, as the goals for child welfare systems in each state. To assess each state's progress against these measurements, ACF instituted periodic Child and Family Services Reviews (CFSRs).

As the OPE report acknowledged, Idaho's initial review occurred in May 2003 and identified several deficiencies. The deficits appeared in each of the three outcome areas (safety, permanency, and well-being) as well as in four of seven systemic factors: quality assurance system, training, service array, and case review system.

The upshot of this CFSR was the Department's development and implementation of Idaho's Program Improvement Plan (PIP). In the course of just two years from ACF's acceptance of the Idaho PIP in February 2004, Idaho completed a formidable set of goals through a series of substantial changes in Department practices. These included:

1. Safety: Improving the timeliness of response to child abuse and neglect referrals from 74% to 94% and reducing repeat maltreatment from 9.3% to 6.5%
2. Permanency: Improving the stability of foster care placements from 76% to 92% and increasing child and family involvement in case planning from 44% to 79%
3. Well-Being: Increasing the percent of monthly worker visits with children from 68% to 79% and with parents from 58% to 64%
4. Instituting an intensive case review system to assess randomly selected cases against the CFSR standards in every region on a semi-annual basis (12 quarters of data now collected and analyzed)
5. Promulgating and training to a comprehensive set of 25 Child Welfare and 12 Children's Mental Health practice standards
6. Expanding dramatically the pre-service Academy from 4.5 to 17 days, enlisting the skills and participation of University partners, and implementing a Competency-Based Learning Contract for staff
7. Collaborating with the Court Improvement Project to expedite cases involving Termination of Parental Rights (TPR), train Court personnel on the importance of timely permanence in a child's life, and develop alerts in the judicial database to assist in timely hearing and case monitoring

In its approval letter of April 2006, ACF praised the swiftness and sophistication of Idaho's response and rescinded all potential CFSR monetary penalties. The achievement of all PIP goals in a two-year period with no increase in staff is, in itself, strong testimony to Idaho's success in child welfare workload management.

While Idaho can rightly take satisfaction in completion of its PIP goals, it faces increasingly difficult challenges ahead. The second round of federal CFSRs holds all states to even more stringent standards. Idaho (and all states) must demonstrate achievement of child welfare outcomes at the national 75th percentile. While Idaho did show significant progress in meeting standards set in the PIP, maintaining the status quo in staffing, workload and resource

management, and business practice will be insufficient to clear the higher hurdles set for the next formal CFSR in April 2008.

At the same time the federal government is raising the bar on child welfare outcome standards, Idaho must grapple with trends that continue to exacerbate workload:

1. A population growth rate double the national average (10.4% from 2000 to 2005)
2. Slowing but still increasing foster care placements (53% growth in foster care entries between 2001 and 2006)
3. An inordinately high staff turnover rate (22% in Children's Mental Health and 21.7% in Child and Family Services)
4. Need for additional documentation and accountability (federal "Adam Walsh" requirements)
5. The vicious cycle of extended lengths of stay in foster care increasing the number of cases per worker

III. Department Strategies to Achieve Child Welfare Outcome Standards and Address Workload Issues

The Department is in the midst of an ever-evolving plan to find sustainable methods to meet increasingly stringent federal standards and address workload management. In addition to acting on the results of the Workload Survey, it has identified and begun to implement key strategies, including:

1. Focus on Permanency Outcomes: direct staff and contract resources to concentrate more on permanency decisions as opposed to assessment. Caseload growth is less a factor of new entries into care and more of extended lengths of stay in care.
2. Early Intervention: examine the potential to reduce the number of new entries into care through earlier intervention with in-home services; expediting the return of children to their homes will be the focus of specialized services under contract.
3. Expanded Use of Guardianship: work with the Casey Family Foundation and federal partners to expand guardianship for youth in care with existing foster parents to move more children to permanency and eliminate the need for monthly monitoring visits and ongoing Court oversight. While the Department may continue payment for foster care under a special IV-E waiver, it will not need staff resources for intense monitoring.
4. Streamlined Work Processes: work with a contractor to complete process mapping for risk assessment and case management in order to streamline work processes and to identify improvements in automation; the Department believes it can finance this activity over two years out of existing dollars.
5. Reporting on Inactive Cases: create an automated report to identify inactive cases for supervisors, who can then direct closure of these cases; the Department will examine its standards and process for closure of cases to make this strategy successful.

6. Potential Decision Unit for Additional Social Worker and Clinicain Staff: pursuant to the results of the Workload Survey (described below), the Department will present a request for additional CFS and CMH casework staff.
7. Potential Decision Unit for Resource Development Unit (RDU) staff: as documented in the Workload Survey, the Department should increase RDU staff to achieve an appropriate workload and increase the rate of penetration for foster care children to access IV-E funding. For each percent increase in this IV-E penetration rate, the Department will save $117,000.
8. Hosting a summit on legal representation for the Department: to ensure Department representation in legal hearings required for permanency decisions and termination of parental rights, the Department will work with stakeholders, such as the Courts, State Office of the Attorney General, and the Idaho Prosecuting Attorneys Association, Inc., to determine the best approach to this issue. The criticality of such representation for permanency outcomes (enabling children in foster care to be reunified, adopted, or placed under guardianship in a timely manner) is substantiated by national data on the positive relationship between frequency and regularity of judicial contact and timely permanency decisions for children.
9. Continued Collaboration with the Court Improvement Project: to conduct a reassessment of the judicial system, provide training to judicial personnel on federal laws relating to permanency, and ensure congruence between judicial rules and federal mandates, the Department is convening regular meetings with the Courts, State Office of the Attorney General, and prosecutors.
10. Creation of a "Career Ladder" for Social Workers: to help facilitate retention of the Department's Social Worker staff, the Department is preparing a proposal for a three-tiered Social Worker classification system. With separate classifications for entry-level, professional, and expert Social Workers, the Department will gain flexibility in staff assignments of workload and leadership responsibilities, optimize recruitment and retention, reinforce training and mentoring, and reward veteran staff with opportunities for advancement.
11. Allocation of caseload: through use of a weighting formula reflective of case characteristics.

In summary, the Department is formulating a comprehensive and adaptive set of strategies focused on attainment of child welfare outcomes. It sees the results of the Workload Survey as fully supportive of these strategies and as providing a baseline to monitor the contribution of workload management to the success of these strategies.

The Department now calls attention to describing the AHA Workload Survey in its methodology, quantitative scope, analysis of results, and derivation of a staff allocation model. From this description, the Department will discuss its questions and concerns about the survey's methodology, its plans to use the data, and the contribution of the Workload Survey toward meeting OPE recommendations for Child Welfare Caseload Management.

IV. Overview of Methodology

The American Humane Association (AHA), recognized as a national expert in the growing field of workload management studies, submitted a proposal to create a Task Inventory and use it to guide the development of workload measurement instruments that links: a) established outcomes; b) staff performance required to obtain those outcomes; and c) time needed for different tasks and different case types required for those outcomes.

After commencing the project in January 2006, AHA solicited input from 24 focus groups of CFS and CMH staff in constructing an inventory of 44 tasks, both case-related and non-case-related. AHA organized these 44 Tasks into six broad categories:

1. Contact with Child, with and without others
2. Contact with others
3. Travel
4. Documentation
5. Meetings and Court Time
6. Other- including training, administrative duties, and paid non-work time

The 44 tasks populated the universe of AHA's distinctive workload measurement instrument, known as the Time Data Collector (TDC). For the full one-month period of May 15 to June 16, 2006, the Department required all regional and selected Central Office staff (eligibility determination and adoption staff) to code their time spent into the TDC, on a daily basis, according to the 44 tasks. The participants used the TDC to capture all activity, both case-related and non-case-related, and included overtime.

More than 250 Social Workers and Clinicans as well as their related supervisors and support staff participated, representing an 86% response rate. The survey embodied a "census" approach to record 100% of worker time, rather than a random sample.

The Time Data Collector methodology is eminently re-usable; it can serve as "an on-going method of measuring the amount of time staff spend on different types of cases and activities."

V. Quantitative Scope of the Survey

For the five-week period of May 15 – June 16, 2006, the Workload Survey collected data on:

- 82,273 total hours, of which 48,587 were spent on 11,084 cases – a description of current workload levels
- Of the 48,587 total case-related hours, 34,474 represented CFS staff and the remaining 14,113 depicted CMH staff
- An additional 661 hours spent by the Central Office-based Resource Development Unit (RDU) staff on 3,186 cases, devoted exclusively to eligibility determination
- All case-related activities in each program area: child protection, adoption, licensing, and eligibility determination within Children and Family Services and Children's Mental Health
- All case types for both CFS and CMH, classified as Intake, Assessment, In-Home Service, Out-of-Home Placement

- 253 Social Workers and Clinicans as well as 83 staff in support, supervision, and management, i.e., the 336 of the 383 total child welfare staff who have some degree of regular activity on specific cases

VI. Analysis of Survey Results

A. Summary of Data on Staff Time Spent by Type of Case and Staff Caseload Volume

AHA summarized the hours recorded to determine the average hours per month spent by Social Workers and Clinicans according to different case types. Following is the breakdown for Social Workers in CFS and Clinicans in CMH:

Average Hours Spent per Case

Case Type	Avg. Hours/Mo. Spent per Case by CFS Social Workers	Avg. Hours/Mo. Spent per Case by CMH Clinicans
Intake	1.3	1.6
Assessment	4.2	5.4
In-Home	3.6	4.6
Out-of-Home	10.9	8.5

With the above summary of average hours spent, the number of actual cases as recorded in the TDC, and AHA's delineation of case-related hours spent by CFS Social Workers and CMH Clinicans, the Department can describe how many of different types of cases current staff are serving in a month. AHA determined that CFS Social Workers spend 71% of their available time (or 123.2 hours) on direct case-related tasks, while 63% of CMH Clinician time (or 108.7 hours) is case-related. Accordingly, Department staff, if devoting 100% of their case-related activity to a particular case type, are serving the following numbers of cases per month:

Actual Cases Served per Month

Case Type	Actual Cases/Mo. Served by a CFS Social Worker	Actual Cases/Mo. Served by a CMH Clinician
Intake	92.8	68.5
Assessment	29.5	20.2
In-Home	34.0	23.8
Out-of-Home	11.4	12.8

B. Structured Estimation Analysis of Recommended Staff Time for Type of Case and Recommended Staff Caseload Volume

The above analysis of actual hours spent and cases served differs substantially from the hours needed and resultant caseload sizes required to meet federal and best practice outcome standards.

DHW PERSPECTIVES ON AHA REPORT

As indicated in the section, "Structured Estimation and Standard Setting" (pp. 23-25), AHA convened focus groups of staff in every region to ask them to determine, "how long the work for different parts of a case may take." The same groups also estimated the percentage of cases required to receive service with a task activity in a month.

The multiplication of these two numbers (percent of cases requiring the task AND the time needed to perform the task) yielded estimates of the time a typical case would receive. These estimates were based on the legal, policy, and practice requirements of delivering services to meet the CFSR outcomes for CFS clients and best practice outcomes for CMH clients.

The WASSAM Steering Committee reviewed the results of this "structured estimation" exercise and collaborated with Central Office policy staff in developing a consensus on the times needed at the task level to complete work required by law, policy, and practice requirements. The consensus reached is presented below.

Case Type	Required Hours/Mo. per Case for CFS Social Workers	Required Hours/Mo. per Case for CMH Clinicians
Intake	1.4	1.5
Assessment	9.7	5.5
In-Home	4.7	8.0
Out-of-Home	13.1	14.0

Multiplying the estimates of required hours (or service standards) per case by the respective amount of case-related time available per staff (123.2 for CFS and 108.7 for CMH) produces recommendations for caseload size, based on attaining outcome measures set by the federal Child and Family Service Review (CFSR). The desired caseload sizes are smaller for each of the four case types in CFS, i.e., more staff capacity is needed for each type of case.

The desired caseload sizes are nearly identical for CMH Intake and Assessment, but smaller for In-Home and Out-of-Home.

Case Type	Recommended Cases per Month for CFS Social Worker	Recommended Cases per Month for CMH Clinician
Intake	88.0	72.5
Assessment	12.7	19.8
In-Home	26.2	13.6
Out-of-Home	9.4	7.8

C. Staff Allocation Model Derived from Comparison between Data on Actual Staff Time Spent and Staff Time Recommended to Meet Federal Standards

The comparison between the actual and recommended caseload sizes points to the need to increase staff of both CFS Social Workers and CMH Clinicians. Table 9 (p.28) documents the need to increase CFS social work staff by 36%, amounting to 74.5 Social Workers, 12.2 supervisors, and 11.3 support staff. Table 12 (p.32) presents the case for increasing CMH Clinician staff by 26%, representing 15.9 Clinicians, 2.5 supervisors, and 1.9 support staff.

The summary of additional FTE staff needed to meet federal outcome standards, supplemented by a conservative 3% vacancy factor, is the following:

	CFS	CMH
Needed Case-carrying Staff in FTE	282.5	76.4
Current Case-carrying Staff in FTE	208.0	60.5
Additional Social Workers Needed	74.5	
Additional Clinicans Needed		15.9
Additional Supervisors Needed	12.2	2.5
Additional Support Staff Needed	11.3	1.9
Total Additional Staff Needed	98.0	20.3

As the AHA report is careful to posit, the staff allocation model used in this Idaho survey, "is consistent with the ones used successfully in other states (Arizona, California, and Montana)." The methodology used involved the same use of the Time Data Collector (TDC) instrument to capture actual data and the structured estimation exercise to arrive at recommendations on time needed per case and caseload size.

The need for additional staff is borne out by Idaho's enduring struggle to meet various federal outcome standards. Data from FY06 shows a growth in recurrence of maltreatment, only 77% of cases having monthly contact with child and family (vs. the 90% federal standard), and only 29% of children exiting foster care to adoption doing so within 24 months (vs. the 32% federal standard). Additional staff would increase the number of worker visits, the most important variable to preventing maltreatment and attaining permanency.

As Table 5 (p.24) shows, the recommended hours per case are within the range of other states for Intake and Out-of-Home services. The Idaho recommendation is higher for Assessment but lower for In-Home cases, which renders the recommended caseload sizes comparable as a whole.

D. Staff Allocation for Resource Development Unit

AHA conducted a similar analysis of the work performed by the six-member Resource Development Unit (RDU) (pp.52-55). The RDU staff collect data on each child coming into State care in order to make eligibility determination decisions on funding sources for services to the child. Their charge is to make both initial determination decisions at the child's entry into State care and ongoing re-determination decisions every six months thereafter.

The nature of the data and the small number of staff rendered AHA's analysis and proposed staff allocation difficult. Broadly speaking, AHA found two types of case activity. The first was activity focused on individually identifiable cases, for which the Workload Survey found an average case service time of 43 minutes. The second kind of case-related activity is the verification of eligibility and review of payments, which are performed through automated batch processing and consume just seven minutes of case service time. The combination of specific case activities and batch case activities appear in Table 28, wherein AHA described a workload of 2,706 "batch" cases consuming 319 total hours and 480 individual cases consuming 342 hours.

As Table 29 (p.55) illustrates, this RDU workload of 3,186 cases divided by the targeted caseload of 352 yields a staff allocation of 9.1 social work staff. As contrasted with the current number of 4 Social Workers, the staff allocation asks for 5.1 additional social work staff and fractional increases in supervisors and support.

While the Department lacks full confidence in this particular staff allocation for RDU, it believes that AHA's data collection and analysis are sufficient to meet the OPE Recommendation #7 that the Department "assess the workload and resource needs of the Resource Development Unit, ... determine the level of support needed, ... and conduct a formal analysis to estimate cost savings."

VII. Questions regarding the Survey's Methodology and Results

The Department is confident in the methodology used and results obtained for measuring current workload, determining workload required to meet federal outcome standards, and comparing the workload numbers to develop a staff allocation model. However, questions on the methodology and data arise in the latter half of the report as AHA pursued a more detailed analysis of "Factors Affecting Workload."

AHA selected regional characteristics and case characteristics as significant factors but provided data which the WASSAM Steering Committee and Department Field Program Managers deem incomplete and inconsistent. Accordingly, the Department reserves judgment on the validity of AHA's analysis of : a) regional variation in workload; b) case characteristics; and c) relationship between workload and program outcomes.

DHW PERSPECTIVES ON AHA REPORT

A. Regional Variation in Workload Volume

As described on page 35, AHA grouped cases according to regions and computed average case service times for the four main types of cases (Intake, Assessment, In-Home, and Out-of-Home) in each region. Tables 14 through 17 present the actual cases per month and compare those numbers against the recommended workload standard for cases per month. The comparison between the two sets of numbers is expressed as the percent difference in cases per month by which each region should allocate staff required to meet federal outcome standards.

These percent differences in need for additional staff are summarized for all types of cases in each region in Table 18 (page 40) and below.

	Intake	Assessment	In-Home	Out-of-Home	TOTAL
R1	31%	155%	105%	34%	63%
R2	55%	610%	10%	<-26%>	59%
R3	<-3%>	89%	59%	16%	34%
R4	36%	208%	10%	1%	39%
R5	7%	30%	41%	38%	34%
R6	< -1%>	70%	48%	< -5%>	26%
R7	<-22%>	142%	< -9%>	<-27%>	16%
State	5%	133%	30%	21%	36%

The percentage differences by region, according to the four types of cases, vary considerably. While the statewide totals are congruent with Steering Committee and Field Manager expectations, the Department believes that the definitions of case types lacked inter-regional reliability or were inconsistently followed.

For example, the high percentage increase needed for Assessment in Region 2 (610%) and Region 4 (208%) is clearly outside confidence levels of accuracy and appears to be counter-balanced by the percent difference in In-Home and Out of Home case management. In other words, staff in Regions 2 and 4 appear to have classified more of their work as applying to In-Home and Out of Home cases and much less to Assessment.

The Department believes in the validity of the statewide totals for case type, amounting to the requirement for 36% more staff to meet federal outcome standards. The variation in the regional totals for all cases falls within the expected range, 16% to 63%. There is congruence in the fact that the lowest percentage increases appear in Regions 6 and 7, which have long showed the smallest caseload numbers in the FACS Division's quarterly caseload surveys. These conclusions pertain to data accounting for Children's Mental Health Clinicians as well.

B. Relationship between Case Characteristics and Workload

As the report indicates on pp. 41-44, AHA's Time Data Collector instrument allowed worker-respondents the option of attaching three of sixteen possible case characteristics to the cases on

which they reported activity. AHA explains that it assessed the statistical significance of particular case characteristics affecting the workload through "logistic regression" and summarized the results in Table 21 for CFS cases. In those cases with recorded characteristics, AHA did find substantial increases in CFS workload associated with Intake, In-Home, and Out of Home cases. (AHA found no case characteristic "meaningfully associated" with CMH caseload).

Most intriguing was the identification of the more common case characteristics. Of the cases with coded characteristics, substance abuse was indicated in 67%, parental mental health issues in 54%, and joint involvement with children's mental health in 49%. The percentages pertaining to each of the 16 characteristics appear in Table 19.

In summary, AHA found that the presence of substance abuse increased workload in Intake cases by 50%. Parental mental health issues increased workload in In-Home cases by 30%. Four factors significantly affected workload in Out of Home cases: joint involvement with CMH, parental mental health, siblings in multiple locations, and substance abuse.

While these results suggest that cases could be "weighted" by the presence of such factors, the incomplete and non-random set of data render such inadvisable. Due to the optional nature of the request for this kind of data, worker-respondents entered case characteristic codes in only 890 of the 3,457 family cases, or 25.7%.

Future workload studies should consider the coding of characteristics as mandatory, so that a full set of data is obtained. However, the relatively small sample and the voluntary nature of data entry argue against any use of case characteristics in staff allocation.

C. Relationship between Program Outcomes and Workload

Holding the greatest promise for the Department's workload management is the analysis of the relationship between positive client outcomes and workload for the CFS program. AHA attempted to determine this correlation in the final section of its report, "Workload and Programmatic Outcomes" (pp. 56-62).

AHA summarized regional case workloads by type of case in Table 30 (p. 57) and conducted two statistical tests of the hypothesis that higher case service times were positively associated with better CFS client outcomes. For the client outcome measures, AHA used the 23 items of the federal Child and Family Service Review (CFSR), which represent the Outcome Areas of Safety (items 1 through 4), Permanency (items 5 through 16), and Well-Being (items 17 through 23).

Since there is no corollary to CFSR standards for Children's Mental Health, AHA could not conduct a similar test of the relationship between workload and client outcomes for CMH cases. The CMH program does collect data on the National Outcomes Measures (NOMs), which were established by the federal government in June 2006. Accordingly, future workload studies will have access to CMH baseline data on the NOMs; this Workload Survey did not have such data.

In Table 31 (p.58), AHA discerned "significant relationships" between CFS workload and statewide client outcomes in four items of Intake, two in Assessment, two in In-Home, and four in Out-of-Home cases.

AHA compared regional outcome data, as obtained from the CFS Continuous Quality Improvement (CQI) case reviews, with several national standards. From this comparison appearing in Table 32 (p.61), AHA applied the two statistical tests (Mann Whitney U and Moses) to depict the relationship between higher case service times and higher client outcomes. These tests did "denote a statistically significant relationship between an outcome measure and workload" in five of the twenty comparisons, as evident in Table 33 (p.62).

AHA asserts that "average time per case" (or workload) was related to the listed outcome measures except permanency status upon discharge. Higher "case service time" (or workload) in Intake cases did make a difference in safety outcomes and length of time for reunification. Workload in Assessment cases was associated with fewer placements. Workload in In-Home cases affected safety and likelihood of re-entry into foster care. Surprisingly, there was no significant correlation between workload in Out of Home cases and any of the listed outcome measures.

AHA found definite indications of an empirical connection between workload and client outcomes. There is sufficient evidence to support the premise that management of workload can effect improvement in client outcomes.

VIII. Potential Contributions of the Workload Survey Data

The Department is confident of the validity of data on actual time spent per case and the computation of case service time needed to meet federal outcome standards. The methodologies used were consistent with those of other states and the recommended case service times are comparable to those of other states. At the summary level of describing statewide workload and caseload averages, the Department is secure in its knowledge.

At the more detailed level of measuring workload variation by region, case characteristics, and program outcome, the Department is more guarded. Regional variation by type of case (Intake, Assessment, In-Home, and Out of Home) was too broad to trust completely. The differences associated with case characteristics were instructive but compromised by the voluntary nature of data entry and the resulting small sample of coding in just 26% of all cases.

The Department holds that the workload data strongly supports the need to increase total CFS Social Workers and CMH Clinicians. The allocation of any increased staff or the re-allocation of existing staff must rely on data beyond that captured in this AHA survey. The helpful complement to the workload information is the set of quarterly caseload survey data, which has been collected and analyzed since July 2004.

The following presents the potential contributions of the AHA Workload Survey data and the Department's quarterly caseload survey data to support requests for additional staff, to re-allocate existing staff, and to measure the effect of caseload size on program outcomes. The

Department will also use the Workload Survey data as a baseline against which future survey data can be measured.

A. Budget Request for Additional Staff

AHA compared actual time spent by CFS Social Workers and CMH Clinicians with the case time recommended by the Department's policy and line staff in the "structured estimation" analysis. This comparison yielded a staff allocation model which supports the addition of 98 CFS child protection staff in the Family and Community Services (FACS) Division and 20 Children's Mental Health staff in the Division of Behavioral Health (DBH). The specific numbers of needed staff are:

	CFS	CMH
Social Workers and Clinicans	75	16
Supervisors	12	2
Support	11	2
Total	98	20

The Department is able to use this data as justification to add CFS and CMH staff in a multi-year sequence of budget requests. Recruitment, selection, and training of 75 CFS Social Workers (and 23 ancillary supervisors and support staff) will require several years. Recruitment of Social Workers has proven difficult, particularly in regions outside the Treasure Valley. Training classes in the Child Welfare Academy currently address staff hired to fill positions created by turnover; it is not possible to train more than 15 to 20 additional staff in any one year.

B. Re-allocation of Current Staff

In the absence of new staff to address workload inequities, the Department is committed to an annual review of regional staff allocation, based on data from the quarterly caseload surveys and the Department's Data Warehouse. The Department used caseload and workload data from Calendar Year 2004 as the basis to re-allocate staff for Fiscal Year 2006. This FY06 re-allocation moved two positions from Region 2 to Region 1 and two positions from Region 7 to Region 5.

The annual review for Fiscal 2007 resulted in no change in staffing, with an expectation that the Workload Survey conducted in May-June 2006 would provide a sounder basis for re-allocation in the future. The prospect of any staff re-allocation in FY07 was further complicated by the decision to separate Children's Mental Health (CMH) staff into the new Division of Behavioral Health in June 2006.

The annual review for Fiscal 2008 was conducted in advance of the completion of the Workload Survey. The review considered the regional caseload survey numbers in March 2007 and a separate count of children in out-of-home placement. The caseload averages continued to be the

highest in Regions 3 and 4 and the lowest in Region 6 and 7. Out-of-home placements per worker were highest in Regions 1 and 4 and lowest in Regions 2, 6, and 7 (actual figures are available on spreadsheets). Accordingly, for Fiscal Year 2008, the Department moved two positions each from Regions 6 and 7 to add two staff to Region 4 and one each to Regions 1 and 3.

Similarly, the Division of Behavioral Health decided against any re-allocation of its CMH staff for Fiscal 2008. It will conduct a review of its regional staff allocation in April 2008, pursuant to the Legislature's decision on the request for additional staff.

Now that Workload Survey is complete, the FACS Program Managers have adjusted the regional re-allocation formula to reflect the following weights for designated variables:

No. of Out-of-Home Placements	40%
Staff recommended by the Workload Survey to meet federal outcomes (Table 18 in Survey)	30%
No. of Risk Assessments Performed	15%
No. of Cases open in FOCUS	10%
No. of Child Abuse/Neglect Referrals	5%

The Workload Survey data provide a baseline to "anchor" the results of the continuing series of quarterly caseload surveys. Together these two sources of data will flesh out the above variables and comprise an empirical basis for staff re-allocation.

C. Comparison of Workload Data with Quarterly Caseload Survey Data and the Correlation to Client Program Outcomes

As discussed earlier, AHA did find several instances of a positive relationship between workload "higher case service times" and positive client outcomes. It is encouraging to note as well, the correspondence between CFS caseload and client outcomes in two other databases maintained by the FACS Division.

The first is the set of aforementioned quarterly caseload surveys, which has computed regional caseload averages since July 2004. The second is the set of Continuous Quality Improvement (CQI) client outcome scores, as derived from the quarterly case reviews performed as part of the federal Child and Family Service Review (CFSR) and the CFSR Program Improvement Plan.

The FACS Division analyzed eleven quarters of data on the CFSR case reviews conducted in each of the seven regions. The analysis gave each region a score on meeting client outcomes on the 23 federally-defined criteria – four in Safety, twelve in Permanency, and seven in Well-Being. From these regional scores on client outcomes, one can rank the regions according to degree of attaining client outcomes.

Based on data through September 2006, the following compares the rank of regions along the variables of caseload size (taken from the quarterly caseload surveys) and degree of client outcome attainment (taken from CFSR case reviews):

Rank of Regions in Caseload Size and CFSR Goal Attainment

Region	Rank in Caseload Size	Rank in CFSR Goal Attainment
1	4	4
2	3	5
3	6	6
4	7	3
5	5	7
6	2	1
7	1	2

A review of the regional rankings does show a correlation between low caseload sizes and high client outcome attainment (note Regions 6 and 7). The only anomaly is Region 4 with the highest caseloads correlated with the third-best outcome scores.

The following presents the actual caseload averages and percent of CFSR goal attainment for each of the seven regions:

Region	Sept 06 Caseload	% of CFSR Goal Attainment through Sept. 2006
1	29.6	66.6%
2	26.5	65.8%
3	38.3	59.8%
4	40.6	69.9%
5	35.4	54.8%
6	26.1	78.8%
7	21.7	74.2%

The apparently strong correlation between caseload size and CFSR goal attainment suggests that regional workload should have been more frequently and more strongly associated with CFSR goal attainment. The FACS Division will pursue more refined analysis of workload and client outcomes (CFSR goal attainment) with AHA.

IX. Workload Survey Report in the Context of OPE Recommendations

Recommendation #1: ***To improve caseload management, the Department should take steps to ensure that caseload information is accurate. This may include: a) modifying FOCUS, to count only active cases, and b) establishing a method to collect caseload information outside FOCUS.***

The Department is currently developing the means for enhancing the accuracy of caseload information. By December 2007, child welfare supervisors will be able to generate a regular report on "inactive" cases in the FOCUS system. While the FACS Division continues to track caseload information through quarterly surveys completed manually, it will soon have a FOCUS–generated "active" case report by which it can validate the data on the manual surveys. When data on the FOCUS Caseload Report conforms to those data on the manual surveys, the Department will dispense with the manual counting approach.

Recommendation #2: To obtain workload information..., the Department should: a) employ an on-going method of measuring the amount of time staff spend on measuring different types of cases and activities..., b) analyze key factors that impact the time it takes staff to work cases..., and c) work with a steering committee that includes Department representatives and other stakeholders to develop methods for regular collection of workload information.

As detailed in the above sections of this report, the Department and its contracted vendor, American Humane Association, have pursued all of the actions listed in this recommendation.

Recommendation #3: To ensure program staff are fairly distributed among regions, the Department should use caseload and workload information when making staff allocation decisions, and when measuring ... performance.

As indicated above, the Department has been applying data collected from the quarterly caseload surveys to its annual review of staff allocation. In July 2007, the Department conducted a formal review of definitions used in the quarterly caseload survey to ensure the inter-regional reliability of data. For allocation of any new staff, the Department will use a new formula which includes data from this Workload Survey, the quarterly caseload surveys, and the FOCUS Caseload report.

In measuring "performance," the Department will continue to rely on the 23 federally-defined client outcome measures used in the Child and Family Service Reviews (CFSR). The Workload Survey did find a positive relationship between workload and client outcomes. This relationship also appeared in the comparison of client outcomes by region (data from CFSR case reviews) with caseload averages (data from the caseload survey).

The historical CFSR case review data and the results from the federal on-site CFSR scheduled for April 2008 will delineate the ongoing effectiveness of the Department as well as the contributions of several service initiatives, current and proposed. These initiatives include collaboration with the Court Improvement Project, increased use of guardianships, and early

intervention services, expansion of the Child Welfare Academy to strengthen training of new staff, and a pilot project in developing a FACS Division "career ladder" to reduce turnover.

The Department will continue to collect data on each region to ensure an equitable distribution of staff. However, it must stop short of setting formal caseload standards. The "Case Service Standards" appearing in the Workload Survey are derived from the calculation of staff needed to reach federal client outcome standards. Since these calculations show a need to increase child welfare staff by 36%, it is impossible to set that increase in staff as the standard.

Accordingly, the Department sets the Workload Survey "service standards" as guidelines or targets to reach the federally-defined client outcomes. The Department's goal is attaining client outcomes, not ensuring that every region's caseload reaches a given number. The combination of current caseload management with other service initiatives may well enhance client outcome attainment without meeting the calculated "service standard."

Recommendation #4: To increase program accountability, the Department should annually report accurate caseload and workload information.

By virtue of this Workload Survey and the regular conduct of caseload surveys, the Department has demonstrated the ability to report caseload and workload information on an annual basis.

Recommendation #5: To assess the impact of the "Any Door" initiative, the Department should conduct a formal, in-house analysis....

While the Department has not conducted a formal, in-house, analysis of the "Any Door" initiative, it does have three years of CFSR case review data. Through the client outcome measures in this set of data, one can track any level of change in client outcomes to the stage of Any Door implementation. The Service Integration represented by Any Door was fully implemented in June 2006. While CFS client outcomes have improved since June 2006, the Workload Survey suggests any number of variables could be responsible. It is not clear whether the navigator staff of Service Integration added or detracted from the workload of child welfare staff.

Recommendation #6: To better access Title IV-E funding, the Department should continue to work with the Court Improvement Project....

The Department has forged effective collaboration with the Court Improvement Project (CIP). The RDU unit and Field Program Managers have instituted a "Judicial Tracking System" to identify all cases where IV-E eligibility problems arise due to "untimely Permanency Hearings or faulty language in judicial orders and findings." With data collected monthly since March 2005, the RDU staff has been able to identify specific issues in specific judicial districts to the Court Improvement Project.

The CIP and the Department have collaborated in developing training to and technical assistance guides for judges. They have conducted Permanency Training sessions for judges in each of the seven regions and disseminated written technical assistance guidelines on the specific language for judicial findings.

Recommendation #7: To assess the workload and resource needs of the Resource Development Unit, the Department should ...determine level of support needed... and conduct a formal analysis to estimate cost savings....

As explained above, AHA did include the workload and staff capacity of the RDU in its Workload Survey. The Survey did construct a staff allocation model for RDU, which indicated the need to add five Social Workers and related supervisory and support staff.

X. Conclusion

The Department has fulfilled each of the seven recommendations presented in the Office of Performance Evaluation's report on Child Welfare Caseload Management. Perhaps the most significant accomplishment is the completion of this Workload Analysis Survey and Staff Allocation Model (WASSAM) project, which embodied Recommendation #2 and supported other Department actions in completing the other OPE recommendations.

The Department has validated the use of the Time Data Collector methodology as "an on-going method of measuring the amount of time staff spend on different types of cases and activities." With this data collection approach, the Department established recommendations for case service times needed to meet client outcome standards and derived recommendations for the size of caseload for different types of cases.

The contrast between actual caseloads and the caseloads recommended by the WASSAM survey provide the empirical basis for a staff allocation model. The American Humane Association's analysis supports the premise that Department actions in improving workload management are critical to improving client outcomes.

The Department maintains its primary focus on the attainment of CFS and CMH outcomes. With the results of this Workload Survey, the continuing quarterly case reviews, and the impending CFSR in April 2008, the Department is in position to calibrate its success in meeting these outcomes.

Yet, the Department faces formidable challenges. In addition to more stringent federal outcome standards, the Department continues to struggle with population growth, increasing complexity of cases, inadequate legal representation, and high staff turnover. Maintenance of the status quo is a sure recipe for failure.

However, the Department has demonstrated its capacity to meet these challenges, given the provision of appropriate resources. As a result of completing the CFSR Program Improvement Plan by 2006, the Department has developed the necessary infrastructure, as evident in an ongoing quality assurance system (quarterly case reviews), automated system enhancements and more sophisticated data reporting, an expanded Child Welfare Academy, and establishment of and monitoring to practice standards for both CFS and CMH. The Department has fully engaged its most helpful and skilled partners – the Court Improvement Project, the Casey Family Foundation, and the Child Welfare University Partnership.

DHW PERSPECTIVES ON AHA REPORT

The Department is poised to manage workload more effectively, and in doing so, achieve its primary mission of securing desired outcomes for youth and families.

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Pub. #	Report Title	Date Released
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06-01F	Public Works Contractor Licensing Function	August 2006
06-02F	Idaho Child Care Program	August 2006
06-03F	Timeliness and Funding of Air Quality Permitting Programs	August 2006
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06-05F	School District Administration and Oversight	August 2006
06-06F	Public Education Technology Initiatives	August 2006
06-07F	Higher Education Residency Requirements	August 2006
06-08F	Child Welfare Caseload Management	August 2006
07-01	Use of Average Daily Attendance in Public Education Funding	February 2007
07-02	Virtual School Operations	March 2007
07-03F	Higher Education Residency Requirements	July 2007
07-04F	State Substance Abuse Treatment Efforts	July 2007
07-05F	Idaho School for the Deaf and the Blind	July 2007
07-06F	Public Education Technology Initiatives	July 2007
07-07	Health Insurance Coverage in Idaho: A Profile of the Uninsured and Those with Coverage	July 2007
07-08	Options for Expanding Access to Health Care for the Uninsured	July 2007
07-09F	Child Welfare Caseload Management	December 2007
07-10F	Management in the Department of Health and Welfare	December 2007
07-11F	School District Administration and Oversight	December 2007
07-12	Cataloging Public Health Expenditures in Idaho	December 2007
07-13	Estimating Private Health Expenditures in Idaho	December 2007
07-14	Health Trends in and Drivers of Expenditures in Idaho	December 2007

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